ANNUAL REPORT and FINANCIAL STATEMENTS

2009-10

Ontario

Ontario Health Quality Council

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Letter of Transmittal

September 28, 2010

Honourable Deborah Matthews
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

On behalf of the Ontario Health Quality Council (OHQC), we are pleased to present you with our 2009/2010 annual report. The report reviews the Council's performance for its fourth full year of operations and provides audited financial statements.

In brief, 2009/2010 was a watershed year for the Council. Milestones included the release of an expanded edition of the *Quality Monitor Report*, the launch of a new web-based public reporting system for long-term care and home care – a first for Ontario and Canada – and the implementation of a new provincial initiative aimed at advancing the quality of care in Ontario long-term care homes. With the recent enactment of Bill 46, the *Excellent Care for All Act, 2010*, the Council looks forward to an increased role in promoting evidence-based healthcare.

Thank you for your continued support of the Council's work.

Respectfully,

Lyn McLeod
Board Chair, OHQC

Ben Chan
CEO, OHQC

WHERE WE ARE GOING

Strategic Plan

MISSION

A trusted, independent voice dedicated to informing the public about the quality of its publicly funded health system. A catalyst for improving our health system and our population's health.

VISION

A high-performing health system committed to continuous quality improvement. A system that is there for you when you need it, and involves you in maintaining and improving your own health.

STRATEGY 1
Engaging and reporting to the public

STRATEGY 2
Promoting alignment of indicator frameworks

STRATEGY 3
Building capacity for quality improvement

STRATEGY 4
Developing leadership in quality improvement

VALUES

• Passionate about quality improvement • Objective and guided by evidence
• Public involvement • Health system partnerships • Embracing diversity

WHAT WE DO

Engaging and reporting to the public

The quality of our health system is the responsibility of every Ontarian, and the OHQC with its partners aims to ensure that Ontarians are provided with the knowledge to understand whether quality is improving. Through the public release of its yearly report – *Quality Monitor: Report on Ontario's Health System*, Ontarians are presented with an evidence-based assessment of the quality of Ontario's publicly funded health system relative to nine attributes of a high-performing health system. These attributes represent the extent to which the system is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.

The OHQC takes great effort to ensure that the information it presents is accurate and objective. It does this by partnering with highly respected researchers, choosing performance measures and data sources that are valid and reliable, and by ensuring the content receives thorough scientific review. On June 3, 2010, the OHQC released the 2009 edition of *Quality Monitor*. The expanded edition included more than 150 performance indicators grouped into 35 themes, greater analysis of alternate level of care (ALC) bed days in hospital, more information on safety and staying healthy, the addition of maternal and child health, and expanded coverage of mental health, hospital infections and adverse events. Feedback from our readers suggested that one of the most valuable additions to this year's report was the section featuring a detailed analysis on Ontario's regional Local Health Integration Networks (LHINs), which illustrated progress achieved and opportunities for improvement across dozens of performance indicators.

Prior to the release of its yearly report, the OHQC launched a new web-based reporting system for long-term care and home care, making Ontario the first jurisdiction in Canada to report to the public on the quality of long-term care and home care. In all, 73 homes voluntarily reported their results on pressure ulcers, falls and worsening bladder incontinence. Data pertaining to 32 other indicators related to safety, effectiveness, resident experience and wait times were reported as provincial averages. For home care, information about the quality of care and services provided to long-stay home care clients in 14 regions of the province was made available.

In 2011, the OHQC plans to launch a re-designed website that will provide comprehensive 'one-stop' reporting for the public that is sector specific. Ontarians will be able to find comparable information on quality and satisfaction for long-term care homes and home care, as well as performance measures and comparative data on hospitals. In addition, information by LHINs will facilitate the public's understanding of progress being made and areas for change of its treasured publicly funded health system.

Promoting alignment of indicator frameworks

Improving quality of care requires action at both the policy level and the care delivery level. The policy level typically involves policy makers who develop regulations and make decisions about how to allocate resources. The care delivery level typically involves managers and/or service providers and users of the system whose hands-on care decisions are informed by proven clinical best practices.

The OHQC collaborates with the Ministry of Health and Long-Term Care (MOHLTC), LHINs, healthcare provider organizations, researchers and other healthcare stakeholders to develop indicator frameworks and align measurement with strategy. Ideally, these publicly reported indicators drive health system management decisions. We see the concept of alignment as much more than simply a buzzword taken from the business literature. In our work, achieving alignment means ensuring efforts across the system are made to achieve collective change. As Jan Kasperski, President of the Ontario College of Family Physicians, has said: "*We are a system of pilots with little penetration.*" Aligned performance indicator frameworks ensure that change efforts occur in a uniform, purposeful and focused manner. Aligned performance indicator frameworks ensure that as a system, we are collectively monitoring our gains and losses in the same way.

In this regard, we have been working with the Local Health Integration Network Collaborative to develop a performance framework for Ontario's health service accountability agreements aligned to the OHQC's framework of a high-performing health system. The technical specifications of the indicators publicly reported by the OHQC have been used in the subset of performance and monitoring indicators' accountability agreements. In areas where previous accountability indicators were not aligned, for example, hospital re-admission rates, the OHQC is providing leadership by facilitating discussions with the goal of achieving a common definition to be used in Ontario. The OHQC is actively involved in the alignment initiatives to ensure indicators used by the MOHLTC are indeed aligned with the indicators used for public reporting. This process of aligning frameworks and performance indicators used in MOHLTC initiatives, such as the health system scorecard, is ongoing and will continue to be a high priority for the OHQC.

Building capacity for quality improvement

Leading healthcare systems around the world invest heavily in their staff to develop the skills required to use quality improvement science and tools. Quality improvement also depends on connecting different quality improvement teams working on similar topics, so they can effectively share their experiences on how to implement change. The OHQC's mandate is to support quality improvement and, as such, our approach has been to develop quality improvement resources and cultivate partnerships to support structured quality improvement activities.

In 2009/2010, the OHQC partnered with the Registered Nurses Association of Ontario (RNAO) to train best practice educators to use quality improvement methods in order to reduce pressure ulcers. Thirty long-term care homes participated in this work and over 80% tracked their progress through a common web-database. These teams succeeded in achieving a 50% reduction in the prevalence of pressure ulcers, and many have expanded their improvement focus to new areas in their organization.

These early results, coupled with the new requirement for public reporting in long-term care, created the impetus for a broad-based and multi-year quality improvement initiative for the long-term care sector. The MOHLTC asked the OHQC to work with a coalition of long-term care sector stakeholders in the design of this initiative. With an ambitious mandate of reaching 100 homes per year, the Residents First initiative was introduced in the fall of 2009. This new initiative is designed to support long-term care homes in providing an environment for their residents that enhances their quality of life, through customized training in quality improvement science and practice. It is also aimed at facilitating comprehensive and lasting change by strengthening the long-term care sector's capacity for quality improvement.

Participation in Residents First is voluntary, and the level of interest has been high, with 122 homes registered in the first year, and 150 staff from these homes trained as quality improvement facilitators. As quality improvement facilitators, they act as mentor and coach to their colleagues. Additionally, approximately 70 Collaboratives involving over 466 participants have been held in four regions.

At the same time, a select number of homes receive on-site coaching in LEAN process improvement (a process improvement methodology utilized in the manufacturing sector for decades). All improvement facilitators are also being trained in LEAN, so they can help teams in their homes examine workflow processes, search for ways to reduce duplication, standardize inconsistent steps, and eliminate work that does not add value to the resident.

Developing leadership in quality improvement

Research on high-performing health systems shows that having leadership focused on quality is key to achieving patient-centred transformation. Ideally, quality improvement leaders monitor results for indicators that are important to quality. These leaders also set targets for improvement and develop plans to achieve these targets. At the board level, for example, this may mean setting global targets to improve an institution's quality indicator scores, allocating funds and other resources to support this improvement, setting aside 25% of board meeting time to review quality indicator performance and holding management accountable for the results. Governors and senior managers play an instrumental role in building the culture of continuous quality improvement.

In 2009/2010, the OHQC and the Ontario Hospital Association (OHA) established a partnership to prepare leaders to use quality as a business strategy. Building on the OHA's document: *Quality and Patient Safety: Understanding the Role of the Board*, the OHQC and OHA partnered to design practical tools for hospital boards to adapt and use.

FACILITATING EXCELLENT CARE FOR ALL

Just prior to the release of this annual report, Bill 46, an Act respecting the care provided by health care organizations toward the achievement of Excellent Care for All, received Royal Assent on June 8, 2010. As stated in the preamble of the Bill, "*the people of Ontario and their Government believe in the importance of our system of publicly funded health care services and the need to ensure its future so that all Ontarians, today and tomorrow can continue to receive high quality health care.*" The Council looks forward to acting on its expanded mandate, which will see the organization promoting evidence-based healthcare.

LOFTUS ALLEN & CO.
CHARTERED ACCOUNTANTS

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AUDITORS' REPORT

To the Board of Directors of **Ontario Health Quality Council:**

We have audited the statement of financial position of **Ontario Health Quality Council** as at March 31, 2010 and the statements of revenue and expenses, and cash flows for the year then ended. These financial statements are the responsibility of the organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at March 31, 2010 and the results of its operations and the changes in its cash flows for the year then ended in accordance with accounting principles described in Note 2.

Loftus Allen & Co

Oakville, Ontario
May 21, 2010

CHARTERED ACCOUNTANTS
LICENSED PUBLIC ACCOUNTANTS

STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2010
(with comparative figures for 2009)

	2010	2009
ASSETS		
CURRENT		
Cash	**$ 1,456,210**	$ 1,131,181
Prepaid expenses	**46,998**	84,926
	1,503,208	1,216,107
CAPITAL ASSETS		
Computer and equipment	**126,428**	62,309
Office furniture and fixtures	**80,313**	80,313
Leasehold improvements	**229,479**	229,479
	436,220	372,101
Less: Accumulated amortization	**436,220**	372,101
	–	–
TOTAL ASSETS	**$ 1,503,208**	$ 1,216,107
LIABILITIES		
CURRENT		
Accounts payable and accrued liabilities	**$ 877,358**	$ 925,463
Due to the Ministry of Health & Long Term Care, *Note 3*	**625,850**	290,644
TOTAL LIABILITIES	**$ 1,503,208**	$ 1,216,107

APPROVED ON BEHALF OF THE BOARD:

Laura Talbot-Allan, Director

Lyn McLeod, Director

The attached notes are an integral part of these financial statements.

STATEMENT OF REVENUE AND EXPENSES FOR THE YEAR ENDED MARCH 31, 2010

(with comparative figures for 2009)

	2010	2009
REVENUE		
Ministry of Health and Long Term Care	$ 4,558,186	$ 3,907,900
Speaking engagements	6,854	2,255
Interest	5,510	24,009
Ministry of Health and Long Term Care honoraria – *Note 8*	–	8,000
	4,570,550	3,942,164
ADMINISTRATION EXPENSES – see schedule	2,423,341	1,963,852
RESEARCH	356,639	580,500
COMMUNICATIONS	521,086	1,007,168
QUALITY IMPROVEMENT EXPENSES – see schedule	934,278	–
TOTAL EXPENSES	4,235,344	3,551,520
EXCESS OF REVENUE OVER EXPENSES	335,206	390,644
INTERIM RETURN OF FUNDS TO THE MINISTRY OF HEALTH AND LONG TERM CARE	–	100,000
DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE, *Note 3*	$ 335,206	$ 290,644

The attached notes are an integral part of these financial statements.

SCHEDULE OF ADMINISTRATION EXPENSES FOR THE YEAR ENDED MARCH 31, 2010

(with comparative figures for 2009)

	2010	2009
ADMINISTRATION EXPENSES		
Salaries and benefits	**$ 1,885,349**	$ 1,220,975
Rent	**181,086**	89,417
Computer expenses	**121,256**	58,145
Office supplies, postage, couriers and printing	**50,186**	31,455
Council honoraria	**37,841**	60,355
Publications and memberships	**27,756**	51,563
Financial services	**24,792**	16,050
Human resources services	**21,875**	15,815
Travel	**21,237**	45,079
Telecommunications	**20,130**	23,131
Legal and audit services	**17,183**	8,488
Insurance	**11,006**	9,633
Office equipment and leasehold improvements	**3,644**	333,746
	$ 2,423,341	$ 1,963,852

SCHEDULE OF QUALITY IMPROVEMENT EXPENSES FOR THE YEAR ENDED MARCH 31, 2010

(with comparative figures for 2009)

	2010	2009
QUALITY IMPROVEMENT EXPENSES		
Salaries and benefits	**$ 458,814**	$ –
Learning events	**115,683**	–
Computer expenses	**91,158**	–
Computer equipment	**64,119**	–
Professional fees	**47,702**	–
Office supplies, postage, couriers and printing	**47,993**	–
Human resources services	**47,251**	–
Travel	**19,893**	–
Honoraria	**18,300**	–
Web design and hosting	**14,819**	–
Telecommunications	**8,546**	–
	$ 934,278	$ –

The attached notes are an integral part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2010
(with comparative figures for 2009)

	2010	2009
CASH FROM (USED IN) OPERATING ACTIVITIES		
Cash received from the Ministry of Health and Long Term Care	**$ 4,558,186**	$ 3,587,000
Cash from interest	**5,510**	24,009
Cash from speaking engagements	**6,854**	2,255
Cash paid for administration	**(2,433,518)**	(1,452,324)
Cash paid for research	**(356,639)**	(497,755)
Cash paid for communications	**(521,086)**	(1,004,914)
Cash paid for quality improvement	**(934,278)**	–
INCREASE IN CASH	**325,029**	658,271
CASH, beginning of year	**1,131,181**	472,910
CASH, end of year	**$ 1,456,210**	$1,131,181

The attached notes are an integral part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2010

1. THE ORGANIZATION

The Ontario Health Quality Council (OHQC) is an independent agency, created under Ontario's *Commitment to the Future of Medicare Act* on September 12, 2005. On June 8, 2010, the *Excellent Care For All Act* will be passed in the legislature expanding the Council's role and mandate. The functions of the Council will be:

(a) to monitor and report to the people of Ontario on:
  (i) access to publicly funded health services,
  (ii) health human resources in publicly funded health services,
  (iii) consumer and population health status, and
  (iv) health system outcomes;

(b) to support continuous quality improvement;

(c) to promote health care that is supported by the best available scientific evidence, by,
  (i) making recommendations to healthcare organizations and other entities on standard of care on the health system, based on respecting clinical practice guidelines and protocols, and,
  (ii) making recommendations, based on evidence and with consideration of the recommendations in subclause (i), to the Minister concerning the Government of Ontario's provision of funding for healthcare services and medical devices.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) General

The financial statements are prepared in accordance with Canadian generally accepted accounting principles except for capital assets, which are amortized 100% in the year of acquisition. This policy is in accordance with the accounting policies outlined in the Ontario Ministry of Health and Long Term Care funding guidelines.

(b) Revenue recognition

The deferral method of accounting is used. Income is recognized as the funded expenditures are incurred. In accordance with the Ontario Ministry of Health and Long Term Care guidelines, certain items have been recognized as expenses although the deliverables have not all been received yet. These expenses are matched with the funding provided by the Ministry for this purpose.

(c) Donated materials and services

Value for donated materials and services by voluntary workers has not been recorded in the financial statements. These services are not normally purchased by the organization and their fair value is difficult to determine.

(d) Capital assets

Capital assets purchased with government funding are amortized 100% in the year of acquisition in accordance with funding guidelines.

Furniture and fixtures totaling approximately $17,800 were purchased directly by the Ministry of Health and Long Term Care on behalf of OHQC. These assets are on loan from the Ministry and are not reflected in the balance sheet. These assets cannot be disposed of without Ministry approval and are the property of the Ministry and not OHQC.

3. DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE

Excess revenue over expenses must be repaid to the Ministry of Health and Long Term Care unless specific carry over authorization is provided for all or part of the funds.

	2010	2009
Excess revenue over expenses in 2009	$290,644	$ 290,644
Excess revenue over expenses in 2010	335,206	–
Total repayable at year-end	$625,850	$ 290,644

4. LEASE OBLIGATIONS

OHQC is obliged under a long term property sub tenant lease, which commenced April 1, 2009 and expires March 31, 2015. OHQC was granted access to the unit on March 24, 2009. Annual gross rent under the lease is $170,000. The annual total of rental premises and other obligations during the next five years of the lease are estimated as follows:

	Property	Office Equipment
2011	$170,000	$5,627
2012	$170,000	$5,627
2013	$170,000	$ –
2014	$170,000	$ –
2015	$170,000	$ –

5. ECONOMIC DEPENDENCE

OHQC receives all of its funding from the Ministry of Health and Long Term Care.

6. FINANCIAL INSTRUMENTS

Fair value

The carrying value of cash, accounts payable and accrued liabilities as reflected in the balance sheet approximate their respective fair values due to their short term maturity or capacity for prompt liquidation.

7. COMMITMENTS

OHQC is committed to contracts with various arm's length parties over the next two years to provide services that will enable the organization to fulfill its mandate. These contracts involve future payments in 2011 of $50,000 and in 2012 of $50,000.

8. THE MINISTRY OF HEALTH AND LONG TERM CARE – HONORARIA

In 2009, OHQC received honoraria to compensate for staff time to serve as faculty for two improvement Collaboratives. (A 'Collaborative' is a series of structured learning events supporting specific projects to improve delivery of healthcare services.) A total of $5,000 was received from the Quality Improvement & Innovation Partnership and the Hamilton Family Health Team. A total of $3,000 was received from the South West Community Care Access Centre for the Partnerships for Health – Integrated Diabetes Strategy. The funding for these two Collaboratives originated with the Government of Ontario.

9. COMPARATIVE FIGURES

Certain figures for 2009 have been reclassified to make their presentation identical to that adopted in 2010.

SCHEDULE OF REVENUE, EXPENSES AND BUDGET FOR THE YEAR ENDED MARCH 31, 2010

	ACTUAL	BUDGET
REVENUE		
Ministry of Health and Long Term Care	$ 4,558,186	$ 4,558,186
Speaking engagements	6,854	–
Interest	5,510	–
	4,570,550	4,558,186
ADMINISTRATION EXPENSES	2,423,341	3,253,298
RESEARCH	356,639	307,500
COMMUNICATIONS	521,086	572,838
QUALITY IMPROVEMENT EXPENSES	934,278	424,550
TOTAL EXPENSES	4,235,344	4,558,186
DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE	$ 335,206	$ –

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